

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div><div>I. IDPH Facility ID Number: 0012237</div><div>Facility Name: Norwood Park Home</div><div>Address: 6016 North Nina Avenue Chicago 60631</div><div>County: Cook</div><div>Telephone Number: (773) 631-4856 Fax #: (773) 631-4850</div><div>HFS ID Number: 362170882001</div><div>Date of Initial License for Current Owners: 04/24/1896</div><div>Type of Ownership:</div><div><div><div><div>X</div><div>VOLUNTARY,NON-PROFIT</div></div><div><div>X</div><div>Charitable Corp.</div></div><div><div></div><div>Trust</div></div></div><div>IRS Exemption Code</div><div><div><div></div><div>PROPRIETARY</div></div><div><div></div><div>Individual</div></div><div><div></div><div>Partnership</div></div><div><div></div><div>Corporation</div></div><div><div></div><div>"Sub-S" Corp.</div></div><div><div></div><div>Limited Liability Co.</div></div><div><div></div><div>Trust</div></div><div><div></div><div>Other</div></div></div><div><div></div><div>GOVERNMENTAL</div></div><div><div></div><div>State</div></div><div><div></div><div>County</div></div><div><div></div><div>Other</div></div></div></div> <div><div>In the event there are further questions about this report, please contact:</div><div>Name: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div><div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div><div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div><div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div><div><div>Officer or Administrator of Provider</div><div>(Signed)</div><div>(Type or Print Name)</div><div>(Title)</div><div>(Signed)</div><div>(Date)</div></div><div><div>Paid Preparer</div><div>(Print Name and Title) Cary C. Buxbaum, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div><div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

#	0012237	Report Period Beginning:	01/01/05	Ending:	12/31/05
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)**

Home Health Services

F. Does the facility maintain a daily midnight census? Yes

YES ☒ NO ☐

YES ☐ NO ☒

Date started 04/24/1896

YES ☐ Date _____ NO ☒

YES ☒ NO ☐ If YES, enter number

of beds certified 45 and days of care provided 6,297

Medicare Intermediary Administar Federal

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED		
CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>	

Is your fiscal year identical to your tax year? YES ☒ NO ☐

*** All facilities other than governmental must report on the accrual basis.**

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **72.87%**

Facility Name & ID Number Norwood Park Home # 0012237 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	715,761	66,922	6,000	788,683		788,683		788,683			1
2	Food Purchase		409,822		409,822	(26,864)	382,958		382,958			2
3	Housekeeping	276,072	109		276,181		276,181		276,181			3
4	Laundry	118,462	18,511	162	137,135		137,135		137,135			4
5	Heat and Other Utilities			347,424	347,424		347,424		347,424			5
6	Maintenance	181,282	17,067	514,462	712,811		712,811	(13,247)	699,564			6
7	Other (specify):*											7
8	TOTAL General Services	1,291,577	512,431	868,048	2,672,056	(26,864)	2,645,192	(13,247)	2,631,945			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,378,476	298,440	16,779	3,693,695		3,693,695		3,693,695			10
10a	Therapy											10a
11	Activities	225,713	23,328	2,184	251,225		251,225		251,225			11
12	Social Services	184,185	3,100	2,365	189,650		189,650		189,650			12
13	CNA Training											13
14	Program Transportation			4,790	4,790		4,790		4,790			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,788,374	324,868	44,118	4,157,360		4,157,360		4,157,360			16
	C. General Administration											
17	Administrative	253,030		3,451	256,481		256,481		256,481			17
18	Directors Fees											18
19	Professional Services			137,749	137,749		137,749	(453)	137,296			19
20	Dues, Fees, Subscriptions & Promotions			72,241	72,241		72,241	(15,144)	57,097			20
21	Clerical & General Office Expenses	438,244	16,709	150,632	605,585		605,585	(99,974)	505,611			21
22	Employee Benefits & Payroll Taxes			1,299,396	1,299,396	26,864	1,326,260		1,326,260			22
23	Inservice Training & Education			159	159		159		159			23
24	Travel and Seminar			13,758	13,758		13,758	(2,697)	11,061			24
25	Other Admin. Staff Transportation			209	209		209	(182)	27			25
26	Insurance-Prop.Liab.Malpractice			260,932	260,932		260,932		260,932			26
27	Other (specify):*											27
28	TOTAL General Administration	691,274	16,709	1,938,527	2,646,510	26,864	2,673,374	(118,450)	2,554,924			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,771,225	854,008	2,850,693	9,475,926		9,475,926	(131,697)	9,344,229			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			642,041	642,041		642,041	(217,851)	424,190			30
31	Amortization of Pre-Op. & Org.			534	534		534		534			31
32	Interest			139,168	139,168		139,168	(59,773)	79,395			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			12,600	12,600		12,600		12,600			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			14,724	14,724		14,724	(14,724)				36
37	TOTAL Ownership			809,067	809,067		809,067	(292,348)	516,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		617,874	468,861	1,086,735		1,086,735	(1,235)	1,085,500			39
40	Barber and Beauty Shops	51,236	1,119		52,355		52,355	(52,355)				40
41	Coffee and Gift Shops			2,758	2,758		2,758	(2,758)				41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*	330,600	27,898	224,438	582,936		582,936	(582,936)				43
44	TOTAL Special Cost Centers	381,836	646,891	767,780	1,796,507		1,796,507	(639,284)	1,157,223			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,153,061	1,500,899	4,427,540	12,081,500		12,081,500	(1,063,329)	11,018,171			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(203,142)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,662)	20		28
29	Other-Attach Schedule	(857,525)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,063,329)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,063,329)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Norwood Park Home			
For 0012257			
Report Period Beginning: 01/01/05			
Ending: 12/31/05			
			Sch. V Line
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1	Flowers Expense	\$ (6,750)	21 1
2	Telephone Billing	(21,348)	21 2
3	Miscellaneous Income	(8,824)	21 3
4	Marketing Supplies	(167)	43 4
5	Brochure Materials	(15,100)	43 5
6	Premiums Give Aways New 05	(7,510)	43 6
7	NPH News	(178)	43 7
8	NPH Communicator	(60)	43 8
9	NPH Communicator Postage	(271)	43 9
10	Mktg. Advertising	(12,178)	43 10
11	Advertising - Church Bulletins	(3,415)	20 11
12	Advertising - Program Books	(215)	20 12
13			13
14	Advertising - Miscellaneous	(7,690)	20 14
15	Community Special Events	(9)	43 15
16	Community Special Events Postage	(812)	43 16
17	Special Events	(2,342)	43 17
18	Annual Report	(4,600)	43 18
19	Miscellaneous Expense	(55)	43 19
20	Photography	(446)	43 20
21	Marketing / Admission Salaries	(30,774)	43 21
22	Premiums	(175)	43 22
23	Development Salaries	(118,036)	43 23
24	Allocation of Management & Overhead	(42,647)	43 24
25			25
26	Volunteer Supplies	(208)	43 26
27	Development Supplies Expense	(3,553)	43 27
28	Donor Recognition Events	(1,777)	43 28
29	Membership Dues - Development	(106)	43 29
30	Christmas Appeal Expense	(1,837)	43 30
31	Gift Shop Expense	(2,758)	43 31
32	Picnic Expense	(1,480)	43 32
33	Mothers Day Appeal Expense	(1,524)	43 33
34	Publications including Postage	(5,379)	43 34
35	Honor Roll Expense	(1,345)	43 35
36	Gift Dining Expense	(14,268)	43 36
37	Spaghetti Dinner - Expense	(391)	43 37
38	Fundraising Events - Annual Gala Expense	(23,996)	43 38
39	Gift Annuity Expense	(2,968)	43 39
40	Development Contribution Expense	(244)	43 40
41	Developments Meetings & Conference	(270)	43 41
42	Development Utilities	(2,394)	43 42
43	NPSN Director	(14,047)	43 43
44	NPSN Drivers	(27,160)	43 44
45	Benefits	(1,200)	43 45
46	Allocation of Management & Overhead	(19,148)	43 46
47	NPSN Supplies	(595)	43 47
48	Housecleaning Service Expense	(18)	43 48
49	NPSN Home Care Payroll	(46,478)	43 49
50	NPSN Transportation Expense	(6,828)	43 50
51	NPSN Delivered Meals Expense	(48,901)	43 51
52	Monthly Outings Expense	(327)	43 52
53	NPSN Insurance Expense	(2,340)	43 53
54	Maintenance & Repairs Expense	(163)	43 54
55	Downsizing Program Expense	(16)	43 55
56	NPSN Phones & Pagers	(980)	43 56
57	NPSN Charity Residency	(172)	43 57
58	Trust Fund Expense	(84,223)	21 58
59	Strength Training Income - Outside	(1,235)	39 59
60	Beautician Wages	(51,236)	40 60
61	Beauty Shop Supplies	(1,119)	40 61
62	Income from BRA Inc.	(59,773)	32 62
63	Miscellaneous Income	(8,824)	21 63
64	New Care Assets	(14,709)	30 64
65	R&M Capitalized	(13,247)	6 65
66	Marketing Salaries	(54,185)	43 66
67	Contract Expense - Marketing	(16,589)	43 67
68	Loss on Asset Disposal	(14,724)	36 68
69	Nonallowable Dues	(1,162)	20 69
70	One of Same Price Period Seminar	(2,697)	24 70
71	Marketing Travel	(182)	25 71
72	Health Fair Expense	(197)	43 72
73	Duplicate Legal	(453)	19 73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(857,525)	101

Summary A

12/31/05

[illegible]

Summary B

12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(217,851)											(217,851)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(59,773)											(59,773)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(14,724)											(14,724)	36
37	TOTAL Ownership	(292,348)											(292,348)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,235)											(1,235)	39
40	Barber and Beauty Shops	(52,355)											(52,355)	40
41	Coffee and Gift Shops	(2,758)											(2,758)	41
42	Provider Participation Fee													42
43	Other (specify):*	(582,936)											(582,936)	43
44	TOTAL Special Cost Centers	(639,284)											(639,284)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,063,329)											(1,063,329)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List of Board of Directors		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

Facility Name & ID Number Norwood Park Home # 0012237 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Wells Fargo		X	Addition of Service Corridor	Varies	06/15/98	\$ 1,512,615	\$ 939,493	6/08	3.5%-4.1%	\$ 45,433	1		
2	Wells Fargo		X	Property Expansion	Varies	12/23/04	2,500,000	2,400,000	12/09	3.5%-4.1%	85,073	2		
3	US Bancorp		X	Purchase Telephone System	\$4,205.00	1/1/04	239,309	141,340	04/30/09	0.0600	8,662	3		
4												4		
5	See Supplemental Schedule											5		
	Working Capital													
6												6		
7												7		
8	See Supplemental Schedule											8		
9	TOTAL Facility Related				\$4,205.00		\$ 4,251,924	\$ 3,480,833				\$ 139,168	9	
	B. Non-Facility Related*													
10	Interest Income										(59,773)	10		
11												11		
12												12		
13	See Supplemental Schedule											13		
14	TOTAL Non-Facility Related						\$	\$				\$ (59,773)	14	
15	TOTALS (line 9+line14)						\$ 4,251,924	\$ 3,480,833				\$ 79,395	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2004 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	N/A	8	
	2001		9	
	2002		10	
	2003		11	
	2004		12	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norwood Park Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norwood Park Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,294 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Senior Network - Home Helath Services
Our savior Lutheran Church

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 534 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 534 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	135,036	1896	\$ 20,781	1
2	Facility		2001-2004	2,115,355	2
3	TOTALS	135,036		\$ 2,136,136	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1909	1909	\$189,756	\$		\$	\$	\$	4
5			1924	1924	88,144						5
6			1951	1951	64,220						6
7			1960	1960	294,792			5,896	5,896		7
8			1977	1977	3,847,050			76,941	76,941		8
	Improvement Type**										
9	Various			1961	23,225		20	465	465	21,042	9
10	Various			1977	22,408		20			22,408	10
11	Various			1981	43,739		20			43,739	11
12	Various			1982	84,988		20			84,988	12
13	Various			1983	18,359		20			18,359	13
14	Various			1984	62,349		20			62,349	14
15	Various			1985	90,235		20			90,235	15
16	Various			1986	1,587,965		20	53,850	53,850	1,029,718	16
17	Various			1987	127,214		20	2,836	2,836	127,214	17
18	Various			1988	126,029		20			126,029	18
19	Various			1989	68,666		20	5,739	5,739	107,930	19
20	Various			1990	2,331,319		20	77,774	77,774	1,206,282	20
21	Various			1991	39,209		20			39,209	21
22	Various			1992	82,730		20			82,730	22
23	Various			1993	19,043		20			19,043	23
24	Various			1994	181,618		20	13,532	13,532	144,550	24
25	Various			1995	418,096		20	15,685	15,685	156,872	25
26	Various			1996	39,945		20	1,922	1,922	21,092	26
27	Various			1997	143,897		20	7,197	7,197	61,453	27
28	Various			1998	247,761		20	12,389	12,389	94,071	28
29	Various			1999	3,036,748		20	40,225	40,225	290,908	29
30	Various			2000	145,548		20	7,133	7,133	45,686	30
31	Various			2001	109,327		20	5,466	5,466	27,331	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			627,332			(627,332)		69
70	TOTAL (lines 4 thru 69)		\$ 13,534,380	\$ 627,332		\$ 327,050	\$ (300,282)	\$ 3,923,238	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$13,534,380	\$627,332		\$327,050	\$ (300,282)	\$3,923,238	1
2	Counter Top	2002	2,750		20	138	138	551	2
3	Landscaping	2002	16,814		20	841	841	3,363	3
4	Electrical - Pumps	2002	6,350		20	318	318	1,271	4
5	Plumbing - Kitchen/Dining	2002	13,495		20	675	675	2,700	5
6	Blinds	2002	575		20	29	29	116	6
7	Pump Repair	2002	2,135		20	107	107	428	7
8	Evaporator & Switches	2002	1,333		20	67	67	267	8
9	Pump	2002	2,574		20	129	129	515	9
10	Boiler Repair	2002	1,531		20	77	77	307	10
11	Expansion Valve	2002	2,670		20	133	133	533	11
12	Flooring	2002	20,730		20	1,037	1,037	4,147	12
13	Carpeting	2002	14,579		20	729	729	2,916	13
14	Paging System Repair	2002	952		20	48	48	191	14
15	Doors & Panels	2002	6,995		20	350	350	1,400	15
16	Roof Repairs	2002	7,495		20	375	375	1,500	16
17	Wiring, Pull Stations	2002	3,596		20	180	180	720	17
18	Duct Detectors	2002	5,322		20	266	266	1,064	18
19	Gear Box Assembly	2002	2,330		20	117	117	467	19
20	Carpeting	2003	867		20	43	43	130	20
21	Carpeting	2003	423		20	21	21	63	21
22	Baseboards	2003	256		20	13	13	38	22
23	Carpeting	2003	1,590		20	80	80	239	23
24	Carpeting	2003	826		20	41	41	124	24
25	Lighting	2003	1,794		20	90	90	269	25
26	Carpeting	2003	364		20	18	18	55	26
27	Dining Room Counter Top	2003	531		20	27	27	80	27
28	Cooling Booster Pump	2003	15,370		20	769	769	2,306	28
29	Cooling Rooftop Chiller	2003	17,408		20	870	870	2,611	29
30	Dietary Wall - Lumber	2003	940		20	47	47	141	30
31	Carpeting	2003	821		20	41	41	123	31
32	Compressor - Chiller	2003	3,500		20	175	175	525	32
33	Draperies	2003	1,429		20	71	71	214	33
34	TOTAL (lines 1 thru 33)		\$13,692,724	\$627,332		\$334,967	\$ (292,365)	\$3,952,610	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 13,692,724	\$ 627,332		\$ 334,967	\$ (292,365)	\$ 3,952,610	1
2	Carpeting	2003	320		20	16	16	48	2
3	Security Camera	2003	3,690		20	185	185	554	3
4	Carpeting	2003	430		20	22	22	65	4
5	Carpeting	2003	430		20	22	22	65	5
6	Cooling Equipment	2003	6,297		20	315	315	945	6
7	Cooling Equipment	2003	1,343		20	67	67	201	7
8	Carpeting	2003	433		20	22	22	65	8
9	Cooling Equip Service	2003	3,441		20	172	172	516	9
10	Walk In Freezer	2003	6,627		20	331	331	994	10
11	Cooling Equip - Coil	2003	2,488		20	124	124	373	11
12	Plumbing	2003	1,095		20	55	55	164	12
13	Phone Lease	2003	214,174		20	10,709	10,709	32,126	13
14	Mixing Valve Replacement	2003	1,387		20	69	69	207	14
15	Boiler Repair	2004	1,998		20	100	100	200	15
16	Kda Kitchen Cabinet	2004	786		20	39	39	79	16
17	Boiler Repair	2004	12,770		20	639	639	1,277	17
18	Transmitters	2004	671		20	34	34	67	18
19	Phone Systems S&G Communications	2004	780		20	39	39	78	19
20	Hachigian'S Carpet	2004	877		20	44	44	88	20
21	Hachigian'S Carpet	2004	175		20	9	9	18	21
22	Standard Textile Blind Install	2004	982		20	49	49	98	22
23	Standard Textile Drapes	2004	3,501		20	175	175	350	23
24	Standard Textile - Valances	2004	1,152		20	58	58	115	24
25	Hachigian'S Carpet	2004	492		20	25	25	49	25
26	Hachigian'S Carpet	2004	386		20	19	19	39	26
27	Hachigian'S Carpet	2004	356		20	18	18	36	27
28	Visitor Signs	2004	679		20	34	34	68	28
29	Cooling Equipment Service	2004	7,031		20	352	352	703	29
30	Tuck Pointing	2004	9,600		20	480	480	960	30
31	Talty Tuckpointing	2004	1,400		20	70	70	140	31
32	Cooling Equipment Controls Repair	2004	3,788		20	189	189	379	32
33	Elevator Paint	2004	2,300		20	115	115	230	33
34	TOTAL (lines 1 thru 33)		\$ 13,984,602	\$ 627,332		\$ 349,561	\$ (277,771)	\$ 3,993,904	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$13,984,602	\$627,332		\$349,561	\$(277,771)	\$3,993,904	1
2	Carpet - 240	2004	348		20	17	17	35	2
3	Carpet - 230	2004	607		20	30	30	61	3
4	Johnson Plastice - Fabpb Rowmark Silk	2004	703		20	35	35	70	4
5	Facility Signs	2004	803		20	40	40	80	5
6	Carpet - 146	2004	439		20	22	22	44	6
7	Secure Care Transmitter	2004	1,818		20	91	91	182	7
8	Engraver For Signs	2004	4,830		20	241	241	483	8
9	Secure Care Resident Id Door / Elevator	2004	3,400		20	170	170	340	9
10	Secure Care Resident Alarm	2004	6,800		20	340	340	680	10
11	15" Chrome Dry Pendent Heads	2004	1,375		20	69	69	138	11
12	1/2" Chrome Pendent Sprinklers	2004	1,155		20	58	58	116	12
13	Secure Care Installation	2004	4,800		20	240	240	480	13
14	Secure Care System Tester	2004	1,245		20	62	62	124	14
15	Hachigian'S Carpet - Back Entrance	2004	1,166		20	58	58	117	15
16	Dallia Floor And Wall	2004	4,566		20	228	228	457	16
17	Hi-Tech Surveillance	2004	675		20	34	34	68	17
18	Carpet -140,310 Pavroll Office	2004	1,319		20	66	66	132	18
19	Carpet - 252	2004	448		20	22	22	45	19
20	Carpet - 210	2004	887		20	44	44	89	20
21	Phone System Intall	2004	25,135		20	1,257	1,257	2,514	21
22	Electrical 1St Fl Kitchen	2004	3,684		20	184	184	368	22
23	Powder Rooms Tile	2005	2,284		20	114	114	114	23
24	Interior Door	2005	784		20	39	39	39	24
25	Porch	2005	1,071		20	54	54	54	25
26	Chiller Compressor	2005	13,644		20	682	682	682	26
27	Door Svstem Transmitters	2005	1,794		20	90	90	90	27
28	A/C Sheave	2005	586		20	29	29	29	28
29	New Elevator Brake	2005	5,885		20	294	294	294	29
30	Cooling Condensing Unit	2005	1,415		20	71	71	71	30
31	Secure Care Transmitters	2005	1,080		20	54	54	54	31
32	Fire Suppression System	2005	2,100		20	105	105	105	32
33	Freezer Compressor	2005	3,050		20	153	153	153	33
34	TOTAL (lines 1 thru 33)		\$14,084,496	\$627,332		\$354,556	\$(272,776)	\$4,002,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$14,084,496	\$627,332		\$354,556	\$(272,776)	\$4,002,209	1
2	Carpet	2005	5,831		20	292	292	292	2
3	Drapes	2005	2,049		20	102	102	102	3
4	Lighting & Electrical	2005	1,453		20	73	73	73	4
5	Replace Kitchen Pipes	2005	4,178		20	209	209	209	5
6	Millwork	2005	508		20	25	25	25	6
7	Plastic Liner	2005	2,900		20	145	145	145	7
8	Leaking Pipe Repair	2005	1,719		20	86	86	86	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,103,134	\$627,332		\$355,488	\$(271,844)	\$4,003,141	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 466,924	\$	\$ 47,136	\$ 47,136	10	\$ 199,764	71
72	Current Year Purchases	136,645		13,664	13,664	10	13,664	72
73	Fully Depreciated Assets	2,464,737				10	2,464,737	73
74								74
75	TOTALS	\$ 3,068,306	\$	\$ 60,801	\$ 60,801		\$ 2,678,165	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		See Attached		\$ 86,711	\$	\$ 7,902	\$ 7,902	5	\$ 72,468	76
77										77
78										78
79										79
80	TOTALS			\$ 86,711	\$	\$ 7,902	\$ 7,902		\$ 72,468	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 19,394,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 627,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 424,190	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (203,142)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,753,774	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SEE ATTACHED - 2001	\$ 2,923,841	\$ 14,709	\$ 210,185	86
87	MEAL BAGS - SENIOR NETWORK - 2001	791			87
88	PAINT - 2003	2,728			88
89	PROF FEES - LAND PURCHASE - 2003	480			89
90	LAND - 2004	1,882,922			90
91	TOTALS	\$ 4,810,762	\$ 14,709	\$ 210,185	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 760,557	92
93			93
94			94
95		\$ 760,557	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Storage Rental			12,600			5
6								6
7	TOTAL				\$ 12,600			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
-
- Description:
-

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 208,378	\$		\$ 208,378	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,440			13,440	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,683			237,683	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			9,360	3,766		13,126	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				275,150		275,150	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						338,958		338,958	13
14	TOTAL			\$		\$ 468,861	\$ 617,874		\$ 1,086,735	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,536,490	\$	1
2	Cash-Patient Deposits	1,905,650		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,754		3
4	Supply Inventory (priced at)	40,704		4
5	Short-Term Investments	119,204		5
6	Prepaid Insurance	176,981		6
7	Other Prepaid Expenses	107,827		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,475,610	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,638,841		12
13	Land	4,424,004		13
14	Buildings, at Historical Cost	7,847,533		14
15	Leasehold Improvements, at Historical Cost	5,852,278		15
16	Equipment, at Historical Cost	3,461,867		16
17	Accumulated Depreciation (book methods)	(9,855,923)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	12,819		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	760,557		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,141,976	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,617,586	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 683,698	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,961		28
29	Short-Term Notes Payable	630,094		29
30	Accrued Salaries Payable	420,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,169		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,853		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,278,865		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,034,967	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,850,737		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	30,435		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,881,172	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,916,139	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,701,447	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,617,586	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,004,581	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,004,581	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,696,866	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,696,866	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 18,701,447	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,818,844	1
2	Discounts and Allowances for all Levels	(344,824)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,474,020	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,242,045	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,242,045	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	43,335	12
13	Barber and Beauty Care	60,830	13
14	Non-Patient Meals	7,418	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	662,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,484	20
21	Other Medical Services	389,951	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,166,135	23
	D. Non-Operating Revenue		
24	Contributions	601,916	24
25	Interest and Other Investment Income***	517,472	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,119,388	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	776,778	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 776,778	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,778,366	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,672,056	31
32	Health Care	4,157,360	32
33	General Administration	2,646,510	33
	B. Capital Expense		
34	Ownership	809,067	34
	C. Ancillary Expense		
35	Special Cost Centers	1,724,784	35
36	Provider Participation Fee	71,723	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,081,500	40
41	Income before Income Taxes (line 30 minus line 40)**	1,696,866	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,696,866	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,703	1,950	\$ 77,127	\$ 39.55	1
2	Assistant Director of Nursing	3,279	3,546	117,840	33.23	2
3	Registered Nurses	33,428	36,392	1,049,785	28.85	3
4	Licensed Practical Nurses	24,330	24,330	361,016	14.84	4
5	CNAs & Orderlies	127,775	138,977	1,745,067	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,030	20,856	225,713	10.82	10
11	Social Service Workers	8,461	9,668	184,185	19.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	55,241	61,210	715,761	11.69	15
16	Dishwashers					16
17	Maintenance Workers	10,918	12,204	181,282	14.85	17
18	Housekeepers	26,811	29,401	276,072	9.39	18
19	Laundry	10,349	11,858	118,462	9.99	19
20	Administrator	1,646	1,950	147,725	75.76	20
21	Assistant Administrator					21
22	Other Administrative	1,778	1,950	105,305	54.00	22
23	Office Manager					23
24	Clerical	19,133	20,866	438,244	21.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,842	3,381	27,641	8.18	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	17,468	18,727	381,836	20.39	33
34	TOTAL (lines 1 - 33)	364,192	397,266	\$ 6,153,061 *	\$ 15.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,000	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant		10,275	10-03	38
39	Pharmacist Consultant	Monthly	6,504	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,184	11-03	44
45	Social Service Consultant	Monthly	2,365	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,328		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Park Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Marcia Mahood	CEO	0	\$ 147,725
Michael Toohej	Administrator	0	105,305
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 253,030
B. Administrative - Other			
Description			Amount
Board Development - Meeting Expenses			\$ 3,451
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,451
C. Professional Services			
Vendor/Payee	Type		Amount
Paychex	Payroll		\$ 11,600
Advantage Consulting	Billing/Consulting		60,069
FR&R	Accounting		28,750
See Attached	Legal		37,330
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 137,749
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 108,966
Unemployment Compensation Insurance			39,697
FICA Taxes			441,984
Employee Health Insurance			576,103
Employee Meals			26,864
Illinois Municipal Retirement Fund (IMRF)*			
Employee Gifts			37,369
Pension Expense			69,047
Deferred Compensation			7,333
Misc Employee Benefits			18,897
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,326,260
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			38,779
Health Care Worker Background Check (Indicate # of checks performed 250)			3,028
Dues & Subscriptions			15,290
Yellow Page Advertising			2,662
Advertising & Promotion			11,320
Less: Public Relations Expense (
Non-allowable advertising			(11,320)
Yellow page advertising			(2,662)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 57,097
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			11,061
Entertainment Expense (
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 11,061

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
LSN-\$9,292.98
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$89,368Line10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (9)

Are you presently operating under a sublease agreement?

YESXNO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YESNONOX
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$71,723
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes

SEE ACCOUNTANTS' COMPILATION REPORT

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

Yes
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$26,864
N/A

Indicate the amount. \$
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%Ln14

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

Yes
Frost, Ruttenberg & Rothblatt
Not Complete

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes